Reset Form

UW Health

Financial Statement

UW Health
7974 UW Health Ct
Middleton, WI 53562

877-278-6437
608-833-5039 (Fax)

Applicant Name *(First, Middle, Last)*	Date	Medical Record # (If Known)

For evaluation with the Community Care Program, please include all the following items, as applicable:

- This Financial Statement, signed and dated
- Federal tax returns and supporting schedules (last years)
- Pay stubs (last months)
- Benefit award letters (pension, unemployment, SSI, SSDI)
- Bank statements
- Letter explaining how you are meeting your daily living expenses

Does the patient currently have insurance coverage? ☐ Yes ☐ No

Coverage: _____

If not, has the patient applied for coverage through the Marketplace (Healthcare.gov)? ☐ Yes ☐ No

Does the patient have a HPS (Health Payment Solutions) Insurance Product? ☐ Yes ☐ No

Did the patient/financially responsible party file taxes last year? ☐ Yes ☐ No

If not, why? _____

Does the patient/financially responsible party have a health savings account? ☐ Yes ☐ No ☐ Not Sure

If yes, what is the balance? _____

Patient/Financially Responsible Party

Name *(First, Middle, Last)*	Relationship to Patient	Birth Date *(Month DD, YYYY)*	
Address	City	State	ZIP Code
Phone	Household Size (Patient, Spouse and Dependents)	Marital Status	
Employment Status ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed ☐ Student		If unemployed, last day/month & year worked	
Employer		Employment Date *(Month DD, YYYY)*	

Spouse/Partner

Name *(First, Middle, Last)*	Birth Date (Month DD, YYYY)	Phone	
Address	City	State	ZIP Code
Employment Status ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed ☐ Student		If unemployed, last day/month & year worked	
Employer		Employment Date *(Month DD, YYYY)*	

Dependents

Full Name	**Relationship**	**Birth Date** *(Month DD, YYYY)*
1.		
2.		
3.		
4.		

Next Page

Monthly Income of Financially Responsible Party and Spouse (if applicable)

Patient/Responsible Party		Spouse	
	Monthly Income (Gross)		Monthly Income (Gross)
	Monthly Income (Net)		Monthly Income (Net)
	Hourly Wage		Hourly Wage
	Monthly Social Security Income		Monthly Social Security Income
	SSDI Applied For & Date		SSDI Applied For & Date
	Pension		Pension
	Unemployment		Unemployment
	Checking Acct Avg Monthly Balance		Checking Acct Avg Monthly Balance
	Savings Acct Balance		Savings Acct Balance
	Name of Bank		Name of Bank

Property & Assets

Real Estate Value				Balance on Mortgage	
Make & Model		Owned	Leased	Year: _____	Balance Owned: _____
Make & Model		**Owned**	Leased	Year: _____	Balance Owned: _____

Provide documentation for any of the following sources of income

Income Description	Source	Monthly Income Amount
Cert of Dep/IRA		
401K Withdrawal		
Rental/Property Income		
Other		

Monthly Household Expenses

Rent		Car Payments		Child Care	
Cable TV		Real Estate Taxes		Tuition	
Food		Cell Phone		Electric	
Mortgage		Gasoline		Medication	
Telephone		Heat		Water/Sewer	
Clothing		Insurance Expenses		Other	

Other Bills Owed (Medical Bills, Bank Loans, Credit Cards, Other)

Type	List Name/Use for Loans/Credit Cards	Unpaid Balance	Monthly Payment

Certification

I understand this information will be used only for determination of financial responsibility for my charges at UW Health and will be kept confidential. As part of the Financial Assistance program requirements, I am required to be screened for Medicaid or other public assistance programs, including but not limited to the following: BadgerCare – WI Medicaid; Elderly, Blind, Disabled (EBD); Alien Emergency Medical Assistance (AEMA); Victim of Violent Crime Compensation Fund (VOVC); Presumptive Disability/Medicaid; Social Security Disability/Income (SSD/SSI); Marketplace Health Insurance. My signature authorizes the UW Health to verify any and all information furnished on this form.

Patient/Responsible Party Signature	Date *(Month DD, YYYY)*
Name of person completing form if different from patient	Date *(Month DD, YYYY)*